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Getting men into medicine

Men are finding it increasingly difficult to access a medical career. The current admissions criteria to gain entry to UK medical schools have resulted in more women being accepted than in the past. The situation is similar to 50 years ago, but in reverse, when women found it difficult to obtain a place to train in medicine. Fortunately this under-representation of females has gradually been rectified but now the pendulum has swung the other way. This has resulted in a profession which in future will be deprived of the contribution of men. Patients will find it difficult to see a male GP if they so wish. As the population is composed of approximately equal numbers of males and females would it not be sensible to reflect this in our medical workforce and provide a degree of balance?

According to the Centre for Workforce Intelligence (CfWI) there may not be sufficient numbers in the GP workforce until 2030.¹ This is a worrying situation for both patients and doctors and is partially due to the fewer hours worked by women compared to men. As the current generation of male GPs retires, gaps will be exposed in service provision. By addressing the under-representation of men entering medical school the problem could be ameliorated, as historically men have tended to work longer hours than women and there is no evidence that this is going to change. Perhaps medical schools could review their admissions criteria, which currently favour those who are academically successful in school, and put greater emphasis on other qualities that contribute to the making of 'a good doctor' such as a caring and compassionate nature combined with emotional and physical resilience. Admissions tutors must be aware that boys mature later than girls and the necessary qualities required may not be so evident at age 18 in the male sex. Maybe this later flowering of abilities needs to be given greater recognition during the selection process to help improve this area of developing inequality in the medical workforce.

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REFERENCE

1. Centre for Workforce Intelligence. *GP in-depth review: Preliminary findings*. <http://www.cfwi.org.uk/publications/gp-in-depth-review-preliminary-findings-attachment.pdf> [accessed 27 Feb 2014].

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Top dietary iron sources in the UK

Iron deficiency carries substantial risks, including anaemia and transfusional requirements; suboptimal immune, skeletal muscle, and thyroid function; prematurity; poor maternal and perinatal outcomes in pregnancy; and impaired motor and cognitive development in children.¹ The reference nutrient intake (RNI) for iron is 8.7 mg/day for men and postmenopausal women, and 14.8 mg/day for premenopausal women,² but half of all women in the UK do not consume the 8.7 mg/day RNI.³ Iron requirements are higher still in pregnancy, and following non-menstrual 'haemorrhagic' losses such as blood donation, peripartum, gastrointestinal haemorrhage, surgery, and epistaxis.⁴ Although the proportion of dietary iron absorbed increases in iron deficiency, the degree of compensation for dietary shortfalls is not known.

To assist in advising patients with high iron requirements (patients with frequent epistaxis due to hereditary haemorrhagic telangiectasia), we used gold standard, prospective 7-day weighed food diaries to determine predominant dietary sources of iron in a real-life setting in the UK. We believe

the results will be generally informative for medical practitioners.

The high proportions of dietary iron contributed by fortified cereals and breads were remarkable, particularly as these are not currently listed as good iron sources by NHS Choices,⁵ and were not recognised as such by the study cohort. Participants could consume 87% of the RNI for men and/or postmenopausal women, and 51.4% of the RNI for premenopausal women, through breakfast cereals alone. Iron intake was higher from boxed, fortified cereals (87% maximal contribution to male RNI) than from porridge (5.5% maximal contribution to male RNI). Participants could also consume 51% of the RNI for men and/or postmenopausal women through bread, which included iron-fortified white breads as well as wholewheat. Dedicated vegetarian meals provided similar proportions of dietary iron to red meat. Eggs, fish, and other vegetables (especially potatoes, beans, and lentils) also provided high individual contributions. Conversely, large volumes of inhibitors of dietary iron absorption were ingested, particularly polyphenol-containing tea (average 829 mls/day) and coffee (155 mls/day). Nelson and Poulter⁶ advise that to enhance iron absorption, tea should be avoided 1 hour after an iron rich meal because 150 ml reduces non-haem iron absorption by 60–80%.

These data provide an easy route to identify individuals at risk of iron deficiency, and simple advice to address, particularly suggesting a bowl (or extra bowl) of their favourite iron-fortified breakfast cereals, and reducing tea and coffee intake with meals. The data may also help patients with iron overload states aiming to reduce dietary iron intake.

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REFERENCES

1. World Health Organization. *The World Health Report 2002: reducing risks, promoting healthy life*. http://www.who.int/whr/2002/en/whr02_en.pdf [accessed 3 Mar 2014].
2. Department of Health. *Dietary reference values for food energy and nutrients for the United Kingdom*. London: HMSO, 1991.
3. Thane C, Bates C, Prentice A. Risk factors for low iron intake and poor iron status in a national sample of British young people aged 4–18 years. *Public Health Nutr* 2003; **6**(5): 485–496.
4. Fennimore H, Le Couteur J, Hickson M, *et al*. Hemorrhage-adjusted iron requirements, hematinics and hepcidin define hereditary hemorrhagic telangiectasia as a model of hemorrhagic iron deficiency. *PLoS One* 2013; **8**(10): e76516.
5. NHS Choices. Iron deficiency anaemia. <http://www.nhs.uk/conditions/Anaemia-iron-deficiency-/Pages/Introduction.aspx> [accessed 3 Mar 2014].
6. Nelson M, Poulter J. Impact of tea drinking on iron status in the UK: a review. *J Hum Nutr Diet* 2004; **17**(1): 43–54.

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Befriending services for people with sight and hearing loss

Following on from December's theme of *Vulnerable People* I am writing to raise awareness about a service available to people with a combined sight and hearing loss who may present with other conditions.

Without sight and hearing, which most of us take for granted, people can become lonely, socially isolated, and detached from their local community.

Deafblind UK is a national charity which provides emotional and practical support for people with a combined sight and hearing loss, as well as carers and professionals. In addition to a free information and advice line and advocacy service, the charity runs befriending services in several parts of the UK for people with both sight and hearing loss which causes difficulties in communication, access to information and mobility. Its aim is to promote better mental health and wellbeing by reducing the feeling of isolation so often felt by deafblind people.

Deafblind UK works closely with local social services and sensory teams and has recruited some brilliant volunteers to support people in their local area. It is looking to link

up with all professionals who come into contact with people who have both a visual and hearing impairment for mutual benefit. GPs and health visitors are invited to refer all patients who they think would benefit from Deafblind UK's services, with their permission. People who have recently lost both sight and hearing could be supported before they become isolated and this would bring both short- and long-term benefits to these individuals and to healthcare services.

We aim to identify as many people as possible who are deafblind or have both sight and hearing loss and invite them to take up free membership of Deafblind UK. This will enable them to access Deafblind UK's free information and advice line, support for carers and our Befriender service as well as a quarterly magazine in accessible formats and tactile birthday and Christmas cards.

The goal of the Befriender service is to enhance the member's quality of life by linking them with someone to meet with them regularly for a chat or to keep in contact via email or telephone if they would prefer. The local community services officer meets with members in their home initially, to get to know them and find out how they would best like to be supported. They then identify a volunteer to link with them. Please note, all volunteers are DBS checked before commencing any work with Deafblind UK.

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Shisha: is this addressed within smoking cessation in general practice?

Waterpipe tobacco smoking has become a widespread practice. In the UK, shisha smoking has been taken up by many, reflected in the increased number of shisha lounges and cafes. The evidence of the harmful effects of shisha smoking is growing and an association with lung cancer and respiratory illness has already been identified.¹ Eissenberg found that, relative to cigarette smoking, shisha smoking is associated with greater carbon monoxide exposure and significantly more smoke

exposure.² We wanted to explore whether this form of smoking is being addressed by healthcare professionals in general practice.

In a cross-sectional study of 50 general practices in the West Midlands 4% of responders did not know what shisha was, while 16% of primary care healthcare professionals thought that shisha smoking is a problem in their locality. When clarifying a patient's smoking status, 76% do not enquire about smoking shisha. Only 10%, sometimes or always, include shisha smoking in their smoking cessation advice; 36% of healthcare workers feel that one shisha pipe is equivalent to 16–20 normal strength cigarettes, whereas 20% feel it is equivalent to 0–5 cigarettes.

Enquiring about shisha seems to be done poorly in general practice in the West Midlands, and we believe a greater awareness and understanding of shisha is needed among healthcare professionals providing smoking cessation advice. The World Health Organisation suggests that a shisha smoker may inhale the smoke of up to 100 or more cigarettes during an estimated 20–80-minute session of smoking.³ We feel that it is necessary for those engaged in smoking cessation to ask 'the shisha question'.⁴

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REFERENCES

1. Akl EA, Gaddam S, Gunukula SK, *et al*. The effects of waterpipe tobacco smoking on health outcomes: a systematic review. *Int J Epidemiol* 2010; **39**(3): 834–857.
2. Eissenberg T, Shihadeh A. Waterpipe tobacco and cigarette smoking: direct comparison of toxicant exposure. *Am J Prev Med* 2009; **37**(6): 518–523.
3. World Health Organization. WHO Study Group on Tobacco Product Regulation. *Waterpipe tobacco smoking: health effects, research needs and recommended actions by regulators*. http://www.who.int/tobacco/global_interaction/tobreg/waterpipe/en/ [accessed 3 Mar 2014].
4. Jawad M, Khaki H, Hamilton F. Shisha guidance for GPs: eliciting the hidden history. *Br J Gen Pract* 2012; **62**(595): 66–67.

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